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MICHAEL RODAK, JR., CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1976

No. **76-105**

FAITH HOSPITAL ASSOCIATION,
Petitioner,

v.

BLUE CROSS HOSPITAL SERVICE, INC. OF ST. LOUIS, Doing Business as
Blue Cross Plan of St. Louis, BLUE CROSS ASSOCIATION, GENERAL
AMERICAN LIFE INSURANCE COMPANY, and CASPER W. WEINBERGER,
Secretary of Health, Education and Welfare,
Respondents.

PETITION FOR A WRIT OF CERTIORARI

To the United States Court of Appeals
for the Eighth Circuit

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**To the United States Court of Appeals
for the Eighth Circuit**

Faith Hospital Association (hereinafter referred to as Faith Hospital) respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Eighth Circuit entered in this proceeding on April 12, 1976.

OPINIONS BELOW

The opinion of the Court of Appeals, not yet reported, appears in Appendix A hereto. The opinion of the District Court

is not reported and appears in Appendix B hereto. The opinion of the Blue Cross Provider Appeals Committee appears in Appendix C hereto.

JURISDICTION

The judgment of the Court of Appeals for the Eighth Circuit was entered on April 12, 1976. A timely petition for rehearing or for rehearing en banc was denied on May 4, 1976, and this petition for certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

QUESTIONS PRESENTED

1. Should the interpretation of 42 U.S.C. §405(h) by this Court in the Social Security Act case of *Weinberger v. Salfi*, 422 U.S. 749 (1975), be extended to Medicare Act cases where the result would be to prevent judicial review in a large category of cases and accord finality to an adjudication by a private non-governmental organization?

2. Does the District Court have jurisdiction under 28 U.S.C. §1331 of an action by Petitioner to recover \$189,775 in Part B Medicare Act payments wrongfully withheld by Respondents?

3. Does the District Court have jurisdiction under the Administrative Procedure Act, 5 U.S.C. §§702-706, to review a decision by the Blue Cross Provider Appeals Committee?

4. Do the words "reasonable charge" for physicians' services as used in 42 U.S.C. §1395(1)(a)(1) mean the customary charge in the market place for such services or do such words include only the cash-in-hand received by the physician and exclude both that portion of the charge which he remits to the hospital provider in payment of the physician's overhead costs at the hospital and that portion of the charge which he donates to the hospital provider?

STATUTORY PROVISIONS INVOLVED

42 U.S.C. §405(h) provides as follows:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this sub-chapter.

42 U.S.C. §405(g) provides in pertinent part as follows:

Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

5 U.S.C. § 701(a) provides as follows:

This chapter applies, according to the provisions thereof, except to the extent that—

(1) statutes preclude judicial review; or

(2) agency action is committed to agency discretion by law.

5 U.S.C. § 702 provides as follows:

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within

the meaning of a relevant statute, is entitled to judicial review thereof.

5 U.S.C. § 704 provides in pertinent part as follows:

Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review.

28 U.S.C. § 1331(a) provides as follows:

The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of \$10,000, exclusive of interest and costs, and arises under the Constitution, laws, or treaties of the United States.

STATEMENT OF THE CASE

Petitioner-plaintiff Faith Hospital is a Missouri not-for-profit, charitable corporation operating a 116 bed hospital in the City of St. Louis and a 132 bed hospital in St. Louis County (App. 6a, 9a-10a, 27a¹). It is a "provider" of hospital services under Part A and Part B of the Medicare Act, 42 U.S.C. §§ 1395-1395pp (1970). Part A of the Act is primarily designed to provide "basic protection against the costs of hospital and related post-hospital services" for individuals aged 65 and over (42 U.S.C. § 1395c). Part B of the Act is a voluntary health insurance program by which the Federal Government through the Secretary of Health, Education and Welfare, will, in return for a monthly premium, pay up to 100% of the "reasonable charges" for services rendered primarily by physicians (42 U.S.C. § 1395r, 1395s, 1395(1)(a), 1395k(a)(B)).

Respondent-defendant Blue Cross Association (hereinafter sometimes referred to as "BCA") has an agreement with the

¹ References are to the Appendix filed in Court below by respondents.

respondent-defendant Secretary of Health, Education and Welfare (hereinafter sometimes referred to as "HEW") by which BCA can act, with the consent of a hospital provider of services, as an intermediary for HEW in administering the provisions of the Medicare Act (App. 7a, 18a, 9a). BCA can delegate its duties as intermediary, and in this instance did delegate those duties, to respondent-defendant Blue Cross Hospital Service, Inc. of St. Louis (hereinafter sometimes referred to as the "Plan") (App. 7a-9a). Respondent-defendant General American Life Insurance Company (hereinafter sometimes referred to as the "Insurance Company") is the fiscal agent for HEW to handle disbursements under Part B of the Medicare Act (App. 7a, 9a).

Faith Hospital utilizes the services of certain physician-specialists such as radiologists, pathologists, cardiologists, and anaesthesiologists (App. 27a). Effective June 1, 1966, and in accordance with an oral agreement, these physician-specialists deposited \$5,000 with Faith Hospital as their initial payment of the cost of operating their respective departments in radiology, pathology, cardiology, and anaesthesiology (App. 27a). The doctors billed their patients directly a reasonable charge for their services and Faith Hospital acted as fiscal agent for the doctors and collected all such charges. It has never been contended that such charges were not reasonable, and they were the same charges that were billed to non-Medicare patients (App. 32a-33a, 52a).

These funds were deposited, until September 29, 1967, in a special account designated "Faith Hospital Agency Account—Medical Specialist Services" (App. 27a-28a). After September 29, 1967, these funds were deposited in the general account of Faith Hospital except for the initial \$5,000 which was placed in a savings and loan account designated "Advance Deposit by Hospital Based Physicians" (App. 28a). From the funds received by Faith Hospital acting as fiscal agent for the doctors, the doctors were debited for their operating expenses in connection with running the various departments. At the request of the doctors, a further amount was retained as a donation by the

doctors to the hospital. The balance was remitted to the physicians (App. 28a, 51a-52a).

In billing patients for hospital services covered under Part A of the Act, Faith Hospital did not charge as a cost factor any of its expenses of operation of the radiological and other departments which were paid by the physician-specialists to the hospital and constituted part of the physicians' charge under Part B of the Act (App. 29a).

All of the foregoing arrangements were discussed at length with defendant Blue Cross Hospital Services, Inc. (the "Plan") and it was agreed that the arrangement was a proper one (App. 28a). The Plan required that Faith Hospital not include in its Part A billings expenses of operations included in the Part B billings of the physician-specialists (Letter dated March 15, 1967 [paragraph 4]; App. 43a). This requirement was scrupulously adhered to (App. 29a). Defendant Insurance Company, acting as fiscal agent for HEW, approved the arrangement and specifically required that the physician-specialists bill the patients directly, which was done (Letter dated March 9, 1967; App. 42a).

In the year 1972, Faith Hospital was informed by the Plan that there had been an overpayment under Part B in the amount of \$189,775 (App. 10a). This amount represented payments under Part B for the services of the physician-specialists in excess of the amounts actually received by these physicians and exclusive of the operating expenses of the radiological and other departments (App. 50a).² It was contended that the amounts retained by the Hospital and not remitted to the physician were not allowable as follows (App. 50a):

² In its audit, the Plan gave Faith Hospital a credit under Part A for the operating costs of the various departments which had been allocated to Part B. Thus, the \$189,775 actually represents the contribution or donation element. It does not include the amounts paid to the physician-specialists since that was admitted to be a proper Part B charge, and it does not include operating costs for the radiological and other departments since that element was credited to Faith under Part A as a reasonable hospital cost.

Year Ending May 31, 1967	\$ 42,052
Year Ending May 31, 1968	58,058
Year Ending May 31, 1969	76,031
Year Ending May 31, 1969 (Faith Hospital West)	13,634
	<hr/>
	\$189,775

The Plan withheld \$64,492 due the Hospital from the Plan as intermediary under Part A and threatened to eliminate Faith Hospital as a participant under Part A unless it paid the \$189,775. Beginning April 1, 1972, the Hospital paid the Plan the alleged overpayment at the rate of \$10,440 per month under an agreement that the Plan would return the money if the Hospital successfully prosecuted its appeal to the Blue Cross Provider Appeals Committee, established by an agreement between HEW and the Blue Cross Association (App. 10a-11a; Appendix A).

The Hospital did appeal this alleged overpayment to the Committee which, on February 23, 1973, unanimously ruled in favor of respondents (App. 16-22a; Appendix C *infra*). Thereafter, on April 23, 1973, the Hospital filed this suit in District Court (App. 2a).

The complaint filed in District Court is in three counts seeking review of the determination by the Blue Cross Provider Appeals Committee (hereinafter referred to as the "Committee") that respondents were entitled to a reimbursement from Faith Hospital under Part B of the Medicare Act for patient care services rendered by the physician-specialists (App. 6a-15a). Count I alleged that the decision by the Committee was arbitrary, capricious, wrongful, improper and not in accordance with the law (App. 12a-13a). Count II alleged that the Committee was not impartial and unbiased and had a built-in deference in favor of respondents and that therefore Faith Hospital was denied its due process right to a fair and impartial administrative review (App. 13a-14a). Count III alleged that respondents' claim

to reimbursement of \$189,775 was barred by the limitations principle contained in 42 U.S.C. § 1395gg(c) (App. 14a-15a). Respondents filed a Motion to Dismiss all counts (App. 3a, 57a).

On February 26, 1975, the District Court (Honorable H. Kenneth Wangelin) dismissed Count I for lack of jurisdiction (App. 57a-60a; Appendix B hereto). As to Count II, the Court denied the motion to dismiss and went on to uphold Faith Hospital's contention in Count II that the Committee was not impartial and unbiased and that Faith Hospital had therefore been denied due process (App. 58a-60a). The Court dismissed Count III on the ground that, as a matter of law, respondents' claim for reimbursement was not barred by 42 U.S.C. § 1395gg(c) (App. 59a). Faith Hospital appealed the decision on Counts I and III and respondents appealed the decision on Count II (App. 61a).

On appeal to the Court of Appeals for the Eighth Circuit, the Court affirmed the dismissal of Count I for lack of federal jurisdiction on the authority of § 405(h), 42 U.S.C., of the Social Security Act and this Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975). (See Appendix A) While acknowledging that its decision was in conflict with decisions in other circuits, the Court below felt it was obliged to extend *Salfi* to this Medicare Act because § 405(h) and other sections of the Social Security Act are incorporated "to the same extent as they are applicable" into the Medicare Act by 42 U.S.C. § 1395ii. Accordingly, the Court of Appeals held that § 405(h) precluded any judicial review of the administrative determination by the Blue Cross Provider Appeals Committee.

As to Count II, the Court below held that the District Court had jurisdiction to review due process objections to the administrative procedures adopted by the Secretary of HEW to determine Medicare reimbursements. It went on to hold that § 1395(a), 42 U.S.C., required review "by the Secretary" and that there-

fore the Secretary exceeded his statutory authority by delegating that duty of review to the Blue Cross Provider Appeals Committee. The Court held that the Secretary should review the Committee determination and remanded the case to the Secretary for that purpose.

As to Count III, the Court affirmed the dismissal on the grounds that there was no statute of limitations bar to the Secretary's claim for recoupment.

REASONS FOR GRANTING THE WRIT

1. The Decision Below Conflicts With the Decisions of Other Courts of Appeals as to the Proper Interpretation of 42 U.S.C. § 405(h).

The decision below is in direct conflict with decisions in the Second, Fifth and Ninth Circuits. *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973); *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971); *Dr. John T. MacDonald Foundation, Inc. v. Mathews*, Fifth Circuit, No. 75-2966, decided July 2, 1976; *Mount Sinai Hospital v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), *certiorari denied, rehearing denied*, 522 F.2d 179 (1975), *cert. denied*, 96 S.Ct. 1665 (1976); *Rothman v. Hospital Service*, 510 F.2d 956 (9th Cir. 1975).

The Court below acknowledged that its decision was in conflict with decisions in other circuits but felt justified in rejecting them on the basis of this Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975). (See Appendix A hereto.) In *Salfi*, a widow and child, after their claims for social security benefits were rejected by the Social Security Administration, brought a class action on behalf of themselves and all others similarly situated in a 3 judge District Court. Jurisdiction was claimed under the federal question statute, 28 U.S.C. § 1331, and the claim was made, and upheld by the District Court, that certain sections of the Social Security law were constitutionally invalid.

This Court held that the District Court did not have jurisdiction under 28 U.S.C. § 1331 because of the third sentence of 42 U.S.C. § 405(h) which specifically provides:

No action against the United States, the Secretary, or any officer or employee thereof shall be brought under [§§ 1331 et seq.] of Title 28 to recover on any claim arising under [Title II of the Social Security Act].

See quotation of statute in *Salfi* at 422 U.S. 749, 95 S.Ct. 2457, 2462 (1975). The Court went on to hold, however, that the District Court did have jurisdiction under the jurisdictional grant contained in 42 U.S.C. § 405(g) as to the widow and child since they had met the requirements of § 405(g) by exhausting their administrative remedies, but that there was no § 405(g) jurisdiction as to the unnamed members of the class since they had not exhausted their administrative remedies.

The Court below felt that the *Salfi* Social Security Act decision was applicable to this Medicare case because § 405(h) and other sections of the Social Security Act are incorporated "to the same extent as they are applicable" into the Medicare Act by 42 U.S.C. § 1395ii.

But, as the Second Circuit held in *Kingsbrook*, *supra*, a Medicare Act case, the limitations of § 405(h) "apply only where a litigant sought to by-pass the judicial review procedures provided by the Medicare Act." 486 F.2d at 666. In *Salfi*, the litigants did seek to by-pass the judicial review procedures available to them under § 405(g). Here, however, Faith Hospital, like the Kingsbrook Jewish Medical Center, has not sought to by-pass any judicial review procedures; indeed, it has no judicial review procedures otherwise available to it under the Medicare Act. And as the Court held in *Kingsbrook*, *supra*, at page 667:

[B]ecause of considerations of due process, *all* of the restraints on judicial action included in section 405(h) are inapplicable where the Medicare Act provides no procedure for judicial review. Consequently, we find jurisdiction to hear Kingsbrook's claim under 28 U.S.C. § 1331. (Emphasis in original.)

In short, contrary to the decision below, the jurisdictional bar of Section 405(h) is simply not applicable to Medicare cases in which, as here, the Medicare Act provides no procedure at all for judicial review. In Social Security Act cases, on the other hand, where Section 405(g) does provide for judicial review,

Section 405(h) does bar all other types of judicial review. That is all this Court held in *Salfi* and to extend *Salfi* to Medicare Act cases, as the Court below did, is to prevent all judicial review in a large category of Medicare Act cases and accord finality to an adjudication by a private non-governmental organization, to wit, the BCA Provider Appeals Committee.

2. The Decision Below Conflicts With the Recent Decision of the Court of Claims as to the Proper Interpretation of § 405(h).

It is true, as the Court below observed, that the decisions of the various other Courts of Appeals which the Eighth Circuit has rejected were pre-*Salfi* decisions. However, the decision below, not only conflicts with the post-*Salfi* decision of *Dr. John T. MacDonald Foundation, Inc. v. Mathews*, Fifth Circuit, No. 75-2966, decided July 2, 1976 (Point 1 above), but it is also in direct conflict with the post-*Salfi* decision of the Court of Claims in *Whitecliff, Inc. v. United States*, — F.2d —, CCH, *Medicare and Medicaid*, ¶ 27,819 (May 12, 1976); See Appendix D *infra*.

In *Whitecliff*, a Medicare provider, like Faith Hospital, sought \$213,755 in alleged underpayments and the United States, as it did below, relied on *Salfi* and contended that § 405(h) precluded all judicial review of provider reimbursement disputes. Judge Davis, speaking for the Court of Claims, specifically rejected the Government position and refused to extend the *Salfi* decision to Medicare cases. It adhered to the pre-*Salfi* decisions holding that § 405(h) is not applicable to cases where, unlike *Salfi*, no judicial review at all is provided:

We decline the invitation to extend Salfi's reading of Section 405(h) to this Medicare case. The social security provisions with which the Supreme Court dealt in Salfi authorize appeals of all decisions made after hearings, with out limitation as to issues; the practical effect of the Salfi decision was simply the enforcement of the Section

405(g) procedures and prerequisites to judicial review. See also *Mathews v. Eldridge*, U.S. Sup. Ct. No. 74-204, decided Feb. 24, 1976 (slip op. at 4-10). By contrast, the Medicare statute's express review provisions in effect prior to 1973 apply to extremely limited categories of cases involving providers. *To import into the Medicare program the Salfi preclusion of judicial review (except as expressly authorized) would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like the BCA. Such a result would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review. We cannot assume that the Supreme Court would extend the Salfi interpretation of Section 405(h) to Medicare cases, where the consequences would be so dramatically different, and therefore we adhere to the pre-Salfi view of judicial review of Medicare provider disputes: where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions.* (Emphasis added. Appendix D.)

It is respectfully submitted that Judge Davis' view of *Salfi* and § 405(h) is the correct one. The *Salfi* decision merely obliges parties in Social Security Act cases to meet the § 405(g) procedures and prerequisites to judicial review. To apply *Salfi* to Medicare Act cases, where there is no § 405(g), would be to prevent review of a very large category of cases and issues and to accord finality to adjudications by private organizations like the BCA Provider Appeals Committee. Neither Congress nor this Court in *Salfi* intended any such result which is "of doubtful constitutional validity" and "undermine[s] the normal presumption in favor of judicial review." Certainly such a dramatic result should not be presumed and should not be reached without full briefing and argument by this Court.

3. The Decision Below Is Wrong and the Issue Presented Raises a Live and Important Federal Question Concerning the Proper Interpretation of the Medicare Act and § 405(h).

The decision below applies to all Medicare cases where the accounting period in question ended before June 30, 1973, and since the Medicare Act became law in 1966, there are seven years of cases involved. Judge Davis in *Whitecliff* alluded to the fact that the Government position precludes review "of very large categories of cases" and it is clear that the issue is still very much a live one since the decision in this case and the companion *St. Louis University* case (See Appendix A) was rendered on April 12, 1976, and the *Whitecliff* decision was handed down on May 12, 1976. Moreover, the accounting periods in this case are for the years ending May 31, 1967, May 31, 1968 and May 31, 1969. Still to be litigated, just by Faith Hospital, are the fiscal years 1970, 1971, 1972 and 1973. It seems certain that there are a large volume of cases involving fiscal years ending before June 30, 1973, which are being, or are yet to be, litigated.

Thus, the importance of this case and this issue is not reduced by the fact that in 1973 Congress amended the Medicare Act to create a Provider Reimbursement Review Board whose decisions are reviewable under the Administrative Procedure Act (APA). See 42 U.S.C. § 1395oo (1970) and Appendix A at footnote 8. There still must be many millions of dollars worth of claims being litigated or to be litigated in which this issue is involved.

Moreover, the fact that Congress changed the law to clearly provide for judicial review in no way means that Congress believed that review was not previously provided. As Judge Kaufman pointed out in *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 668 (2d Cir. 1973), the amendment

has little impact on a statute that previously was mute on the subject.

The Court in *Kingsbrook* goes on to point out that the Congressional amendment was most probably a reaction to the Second Circuit's earlier opinion in *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971), that judicial review was available under the APA. Congress decided, in the light of *Aquavella*, to establish particular administrative and judicial review procedures which would become exclusive by operation of § 405(h). Thus, the Congressional amendment was enacted, not because it was believed there was no judicial review previously available but rather because *Aquavella* said judicial review was available and Congress wanted to set forth legislatively the applicable parameters of that review.

The Court of Claims in *Whitecliff* and all of the Courts of Appeal, except for Eighth Circuit in this case, have held that the federal courts do have jurisdiction to review claims for reimbursement by providers under the Medicare Act. It is respectfully submitted that not only is it unfair and unjust that Faith Hospital has no review here but would have been granted such review if it had brought suit somewhere other than in the Eighth Circuit, but also the decision below is simply wrong.

A. There is jurisdiction under 28 U.S.C. § 1331.

Contrary to the decision below, there is jurisdiction in the District Court under the federal question jurisdictional grant of 28 U.S.C. § 1331. This case arises under federal law (the Medicare Act) and more than \$10,000 is involved. The Court would have agreed that there was § 1331 jurisdiction but for its interpretation of *Salfi* and, as previously pointed out, *Salfi* is not in point because it applies only to Social Security Act cases where review by the Courts is specifically provided for by § 405(g). The Court in *Kingsbrook*, *supra*, specifically held that there is § 1331(a) jurisdiction here. 486 F.2d at page 667.

B. There is jurisdiction under the Administrative Procedure Act.

The District Court also has jurisdiction to review this case under the Administrative Procedure Act (APA), 5 U.S.C. §§ 702-706. The present law in the Eighth Circuit apparently is that the APA is not an independent grant of district court jurisdiction. *Twin Cities Chippewa Tribal Council v. The Minnesota Chippewa Tribe*, 370 F.2d 529, 532 (8th Cir. 1967). But the Courts of Appeal in the District of Columbia and in the First, Fourth, Seventh and Tenth Circuits have all expressly ruled to the contrary. *Pickus v. Board of Parole*, 507 F.2d 1107 (C.A.D.C. 1974); *Bradley v. Weinberger*, 483 F.2d 410 (1st Cir. 1973); *Littell v. Morton*, 445 F.2d 1207 (4th Cir. 1971); *Sanders v. Weinberger*, 522 F.2d 1167 (7th Cir. 1975); and *Brennan v. Udall*, 379 F.2d 803 (10th Cir. 1967).

In this case, however, the Eighth Circuit did not reach the issue whether it should adhere to *Twin Cities*, *supra*, because it held that under 5 U.S.C. § 701(a)(2), the APA does not apply where "agency action is committed to agency discretion by law." The Court below held that Congress by the Medicare Act committed the issue of reimbursement under Medicare totally to the administrator's discretion and therefore intended that there be no judicial review under the APA.

This decision is directly contrary to the Ninth Circuit's decision in *Rothman v. Hospital Service of Southern California*, 510 F.2d 956, 958-960 (9th Cir. 1975), where the Court specifically held that agency action in this type of case is not committed to agency discretion and that therefore the full panoply of judicial review given in the APA is applicable. This includes 5 U.S.C. § 702 which provides that all persons aggrieved by agency action are "entitled to judicial review thereof," and Section 704 which provides for "judicial review" of "final agency action for which there is no other adequate remedy in a court." The decision below on this point is also in direct conflict with the Fifth Circuit's recent decision in *Dr. John T. MacDonald Foun-*

dation, Inc. v. Mathews, No. 75-2966, decided July 2, 1976.

The Court below felt that *Salfi* and § 405(h) preclude judicial review of agency action under the APA. But, as previously pointed out, *Salfi* has nothing to do with judicial review under the APA and § 405(h) is applicable only where, as in Social Security Act cases under § 405(g), judicial review is otherwise provided for. The Tenth Circuit in *Rothman* correctly held that there is no clear and convincing evidence "in the Medicare Act itself or in its legislative history that Congress intended to preclude review of such decisions." *Rothman*, 510 F.2d at page 958.

The decision below in this regard conflicts with the teachings of this Court in *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1971). In that case, this Court relying on its earlier decision in *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967), held that the statutory prohibition on judicial review where the agency action is committed by law to agency discretion "is a very narrow exception" to the right of review and should not be invoked unless there is "clear and convincing evidence" of legislative intent. 401 U.S. at page 410. Only "in those rare instances where 'statutes are drawn in such broad terms that in a given case there is no law to apply' " should judicial review be prohibited. 401 U.S. at page 402.

Such is not the case here. In this instance there is law to apply since the Medicare Act provides for reimbursement of "reasonable charges." 42 U.S.C. § 1395(1). What is or is not a reasonable charge is a legal question clearly subject to judicial review.

The Court below erroneously held that because the Medicare Act specifically provides for judicial review in certain instances but not in others, such as the one involved in the case at hand, Congress had intended to commit all such omitted questions exclusively to agency discretion. This position flies in the face of this Court's holding in *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967), that the mere fact that some actions are made specifically reviewable is not sufficient to support an implication

of exclusion as to other actions. 387 U.S. at 141. The simple fact is that, as the Tenth Circuit held in *Rothman*, 510 F.2d at page 958, there is no clear and convincing evidence of a legislative intent to exclude judicial review of the type of question involved in this case and therefore such review should be afforded.

In short, the APA is an independent grant of jurisdiction to the district courts to review agency decisions and the Medicare Act does not preclude such review in the case at hand. *Rothman* and *Dr. John T. MacDonald Foundation, supra*, were correct in so holding and the court below was in error in reaching an opposite conclusion.

C. The agency decision here is clearly wrong and unjust.

The agency decision here is patently wrong. Part A of the Medicare Act provides for reimbursement to hospitals for the "reasonable cost" of their services. 42 U.S.C. § 1395(1). We are concerned with Part B which provides that physicians are to be reimbursed on the basis of the "reasonable charges" for such services. Thus, 42 U.S.C. § 1395(1) provides in part as follows:

(a) . . . [S]ubject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—(1) in the case of services described in section 1395k(a)(1) [including primarily physicians' services]—80 percent of the reasonable charges for the services; except that . . . with respect to expenses incurred for radiological . . . services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology . . . , the amounts paid

shall be equal to 100 percent of the *reasonable charges* for such services. . . . (Emphasis supplied.)

In the case at hand, it is undisputed that the physician-specialists billed the Medicare patient a reasonable charge (App. 32a-33a). Moreover, the charge to Medicare patients was the same as the charge to non-Medicare patients (App. 52a).

The problem in this case arises over what is legally irrelevant under the Medicare Act: What happened after a patient was billed and then paid this reasonable charge? Faith Hospital, acting as fiscal agent for the physician-specialists, collected the reasonable charges from the patient. From the monies so collected, the physicians paid for their expenses in operating the various departments, withdrew a portion, and donated a portion to the Hospital (App. 28a). The operating expenses had not been charged or collected by the Hospital as a reasonable cost of operation under Part A of the Act (App. 29a). Thus, there was no double charge.³

Respondents have simply taken the legally untenable position that only the amount actually remitted to the physician-specialist by their fiscal collecting agent is reasonable and the operating cost and donation amount cannot be included in Part B. This contention cannot withstand analysis for several reasons:

(1) The contention is against the plain meaning of the law which requires reimbursement of "reasonable charges" of physicians.

(2) A physician-specialist should not be precluded from charging the same as a physician who treats patients only in his office. Thus, such a physician takes X-rays in his office and charges the patient \$100 for which he is reimbursed under Part B because

³ In the audit resulting in the claim for the \$189,775, the Plan gave Faith Hospital a credit under Part A for hospital costs which Faith had collected under Part B. Thus, the \$189,775 represents the contribution element of the reasonable charge since the Plan gave Faith Hospital credit under Part B for those amounts actually remitted to the physicians.

his charge is reasonable. He pays overhead of \$30, contributes \$30 to a charity such as Faith Hospital, and keeps \$40. Surely, a physician-specialist who treats a patient at a hospital should be treated equally under the Medicare Act and be permitted to do the same thing.

(3) The HEW position defeats the purpose of Medicare which is to encourage top flight professional medical services for the elderly. A physician-specialist has been charging Medicare and non-Medicare patients the same reasonable charge. Now, according to HEW, he must charge the Medicare patient less. This result would encourage the physician to favor non-Medicare patients.

(4) The result of the HEW position violates its own regulations which purport to espouse the principle of non-interference by the Government. Thus, 20 C.F.R. §405.481 provides as follows:

Noninterference by Federal Government. It is not the function of the health insurance programs established under Title XVIII of the Act to determine the arrangement which a hospital and a hospital-based physician may enter into for the compensation of the physician. The Secretary will not specify or influence the provisions of the contract or arrangement between hospitals and hospital-based physicians. The hospital and physician can continue to negotiate all aspects of their arrangement to their mutual satisfaction. The principles in this Subpart D are designed to give recognition to the arrangement entered into by a hospital and a physician by establishing criteria for determining, within the framework of the arrangement, amounts payable under the hospital insurance program and amounts payable under the supplementary medical insurance program to the end that the total payments with respect to the physicians' services to the hospital and for the patient are related as closely as is possible to the level of compensation the parties have agreed upon.

Thus, this regulation actually fortifies Faith Hospital's position that all the law requires is that the charge be reasonable and that what happens to the charge thereafter is between the hospital and the physician-specialist.

The nub of the problem seems to lie in the fact that Faith Hospital is acting as a fiscal agent for the physician-specialist. Presumably, if a bank acted as fiscal agent, the Plan would not have made a claim. The physician would have paid the hospital, through the bank, the initial overhead costs. The physician would then draw a portion of the charges and would also, through the bank, make a charitable donation to the hospital. Since the bill to the patient was admittedly reasonable, the Plan would not have objected. Apparently, however, because the hospital, rather than a bank, acted as fiscal agent, the Plan raised an objection and held up funds due the hospital under Part A of the Act.

This position of respondents is simply contrary to the law. At the very least, however, petitioner Faith Hospital should have an opportunity for judicial review of respondents' interpretation of the law, and it should not be obliged to accept the finality of an adjudication by a private non-governmental body such as the Blue Cross Provider Appeals Committee.

CONCLUSION

For each and all of the foregoing reasons, it is respectfully submitted that a writ of certiorari should issue to review the judgment and opinion of the Eighth Circuit.

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APPENDIX

APPENDIX A

United States Court of Appeals
for the Eighth Circuit

No. 75-1301

No. 75-1344

Faith Hospital Association, etc., Appellee-Appellant, v. Blue Cross Hospital Service, etc. et al., Appellants-Appellees.	}	Appeal from the United States Dis- trict Court for the Eastern District of Missouri.
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Submitted: January 12, 1976

Filed: April 12, 1976

Before Gibson, Chief Judge; Clark, Associate Justice, Retired;*
and Bright, Circuit Judge.

Per Curiam.

This case was argued and submitted together with *St. Louis University v. Blue Cross Hospital Service*, — F.2d —, Nos. 75-1274 and 75-1293 (8th Cir. 1976). The issues presented in Faith Hospital's appeal on count I and the Government's cross-appeal on count II are essentially identical to those decided by *St. Louis University* and no purpose would be served by an extended discussion of them. As noted below, Faith Hospital's appeal on the dismissal of count III raises a question not arising in the *St. Louis University* litigation.

Count I of Faith Hospital's complaint makes the same statutory arguments as count I of the complaint of *St. Louis University*. On the authority of that case, we affirm the district court's dismissal of count I for lack of jurisdiction.

* Associate Justice Tom C. Clark, Retired, United States Supreme Court, sitting by designation.

Faith Hospital's count II also parallels the procedural due process claims advanced in St. Louis University's second count. Again, the facts appear to be undisputed. Therefore, we modify the judgment of the district court by eliminating its direction that the Secretary of HEW conduct a *de novo* evidentiary hearing, and we remand to the Secretary for further proceedings as directed in *St. Louis University v. Blue Cross Hospital Service, supra*.

Faith Hospital's third and final count alleges that the administrative recoupment of alleged overpayments after a lapse of more than three years was time-barred by the statute of limitations contained in the Medicare Act. 42 U.S.C. § 1395gg.¹ The district court dismissed count III on the merits. Assuming that we have jurisdiction, we affirm the dismissal of count III.

We agree with the district court's analysis of the statute, 42 U.S.C. § 1395gg, that "after a careful and close reading of the aforesaid [statute] the court finds nothing within [it] which appears to state a statute of limitations for the actions complained of." Moreover, we deem the challenged recovery of a Medicare overpayment by the Secretary, assuming such existed in this case, was not against equity and good conscience. We reject the argument made by appellant that since any overpayment to Faith Hospital resulted from the error of an insurance company fiscal intermediary, in this case the Blue Cross Plan of St. Louis, the equities lie with Faith Hospital, again assuming that the hospital actually received an overpayment of Medicare funds.

A true copy.

Attest

Clerk, U.S. Court of Appeals, Eighth Circuit

¹ On this appeal, Faith Hospital has abandoned its earlier reliance upon § 1395cc.

United States Court of Appeals
For the Eighth Circuit

No. 75-1274.

No. 75-1293.

St. Louis University, etc.,	} Appeal from the United States District Court for the Eastern District of Missouri.
Appellant-Appellee,	
v.	
Blue Cross Hospital Service, etc., et al.,	
Appellees-Appellants.	

Submitted: January 12, 1976

Filed: April 12, 1976

Before Gibson, Chief Judge; Clark, Associate Justice, Retired;* and Bright, Circuit Judge.

Bright, Circuit Judge.

These appeals follow an action brought by St. Louis University challenging certain HEW-mandated procedures and seeking to recover alleged overcharges repaid to HEW by appellant pursuant to an administrative determination by appellees Blue Cross Hospital Service, Inc. of St. Louis and the Blue Cross Association. The dispute arises from services rendered and payments made during appellant's fiscal year end-

* Associate Justice Tom C. Clark, Retired, United States Supreme Court, sitting by designation.

ing August 31, 1966, pursuant to the Medicare provisions of the Social Security Act of 1965.¹ In response to cross motions for summary judgment, District Judge John F. Nangle, on February 18, 1975, dismissed counts I and III of the University's complaint but granted relief on count II. The University appealed the dismissal of counts I and III and defendants cross-appealed the judgment on count II.²

I. Background.

In order to place this case in the proper perspective, the internal organization of St. Louis University must be examined. St. Louis University, as part of its program in the school of medicine, owns and operates a general hospital known as Firmin Deslège Hospital and a psychiatric unit known as the Wohl Institute. These two institutions are known as the St. Louis University Hospitals. The hospitals serve as a teaching and training facility for the school of medicine and provide medical services to both Medicare and non-Medicare patients.

Various types of medical care are provided by the hospital. The category of care involved in this case consists primarily of the services of radiologists but also include pathologists, anesthesiologists, and others. Physicians on the staff of St. Louis University who provide these services to hospital patients also perform teaching duties. In compensation for all their medical and teaching services, they receive a salary from St. Louis University.

Prior to the advent of Medicare in 1966, patients of the St. Louis University Hospital received a hospital bill which contained a single charge for this type of medical care. Taking

¹ P. L. 89-97, July 30, 1975, now codified, as amended, as Subchapter XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395pp. All statutory citations are to Title 42 unless otherwise indicated.

² The complaint contained three counts. Briefly stated, count I alleged violations of applicable statutes and regulations; count II alleged denial of procedural due process; and count III alleged denial of equal protection. For greater detail, see p.6 *infra*.

radiology services as an example, that single charge to the patient included two unidentified components: (1) the charge for technicians, equipment, and overhead used in providing X-rays, and (2) the professional charge of the radiologist.

The Medicare program requires that these components be isolated and treated differently. The first component is termed the "provider component" and provides reimbursement for those types of services which normally are furnished by the hospital itself. This charge is covered by part A of the Medicare program. 42 U.S.C. §§ 1395c-1395i. The second is termed the "professional services component." The professional services component is insured and compensated under part B of the Medicare program. 42 U.S.C. § 1395j-1395w. The Medicare Act provides that the amount of reimbursement under part A (provider component) must be determined on the basis of the "reasonable cost" of such services to the provider; under part B (professional services) the basis is the "reasonable charge."

After the enactment of the Medicare Act, the St. Louis University hospitals adopted an internal accounting procedure which segregated the provider and professional services components on the hospitals' books but not on the patient's bill. Despite this new accounting procedure and even though the professional services component was no greater than the admittedly reasonable charges made by physicians in other area hospitals, the University's claim for reimbursement was disallowed to the extent that the professional services component exceeded the actual cost of the service to the hospital based on a pro rata allocation of the salary of the physicians in question. The University was required to refund to HEW all amounts received under part B which exceeded the salary amount.

Not all physicians on the teaching staff of the University hospitals bill patients through the hospitals. Teacher-physicians in certain specialties traditionally have made charges directly to the patient for their services. For example, surgeons bill the patient directly for an operation, notwithstanding that the surgeon is also a salaried member of the University's teaching staff. The

surgeon's bill is paid directly to him by the Medicare carrier, and the surgeon turns the payment directly over to the University. In turn, the University pays the surgeon a salary. Where billing is done in this manner, Medicare pays the surgeon's entire bill, provided it is reasonable, even though it exceeds his salary.

In some other hospitals radiologists and related specialists customarily bill the patient directly. In those cases, Medicare pays the full reasonable charge even though it exceeds the radiologist's salary. This also is true even if the hospital does the actual billing so long as a separate charge for the physician's service (including radiological and similar services) is set out on the patient's bill and provided that this practice was followed prior to the enactment of Medicare. However, if a hospital did not identify a separate professional services component on the patient's bill prior to Medicare, it cannot obtain full reimbursement by now adopting such a procedure.³

Some explanation must be made of the system by which disputes with regard to Medicare payments are resolved. The Blue Cross Association (BCA) was nominated by the University Hospitals to serve as their fiscal intermediary with HEW. BCA delegated its duties as intermediary to the Blue Cross Hospital Service, Inc. (the Plan), which is a local Blue Cross group in St. Louis. Part B of the Medicare Act is administered through an insurance carrier under the part B supplemental program.

That insurance carrier in this case is General American Life Insurance Company. BCA entered an agreement with the Secretary establishing a five-member Provider Appeal Committee (the Committee). The Committee was to hear appeals by providers who were dissatisfied with the reimbursement allowed by BCA. The agreement required that three of the

³ In this summary of the facts we describe the regulatory scheme as it has been administratively interpreted in this case, explained in the defendants' briefs, and applied to the University. Our statements here should not be taken as expressing any view of the proper interpretation of the regulations.

Committee members be BCA employees—one a BCA vice-president. The other two were appointed by the BCA president from nominees of various national associations of providers. Decisions of the Committee were by majority vote. The agreement specified that decisions of the Committee would be absolutely final.⁴

The University's claim for reimbursement under part B of an amount which its internal bookkeeping identified as the charge for professional services such as those of radiologists, was accepted and paid by the insurance carrier, General American, but later, after an audit, was disallowed by the Plan. The Plan has the responsibility for auditing Medicare payments approved by the carrier. The Plan determined that the University's right to reimbursement under part B for services provided by those specialists who bill through the hospital was limited to the prorata salary paid to those physicians.

The University appealed to the PCA Provider Appeals Committee. The Committee unanimously affirmed the Plan's decision.

When the University lost its appeal before the Committee, it brought this action in district court against BCA, the Plan, and the Secretary of HEW. As we have already noted, *see* note 2 *supra*, the complaint contained three counts. Count I alleged that the Committee's decision violated the Medicare Act and regulations promulgated thereunder. Count II alleged that the makeup of the Committee was unfair and improper and thus violated procedural due process. Count III alleged that essentially identical claims of other providers processed through a different bookkeeping procedure had been approved and paid by Blue Cross and HEW, that this distinction was not rationally

⁴ The appointment of fiscal intermediaries is authorized by § 1395 h(a). Providers have the option of not nominating an intermediary and dealing directly with HEW. However, HEW concedes that the use of an intermediary confers significant benefits. Evidently some providers choose to forego these benefits and deal directly with HEW.

related to any legitimate governmental objective, and that the University therefore had been arbitrarily and capriciously denied the equal protection of the law.

In ruling on cross-motions for summary judgment, the district court dismissed counts I and III for lack of jurisdiction due to sovereign immunity since those counts sought a money judgment, but granted the University relief on count II for denial of procedural due process. The district court determined that the Committee, consisting as it did of a majority of BCA employees, could not afford an impartial hearing to the University. By way of relief, the district court remanded the University's appeal to the Secretary for a *de novo* evidentiary hearing before a tribunal not containing employees of the BCA. The district court also concluded that the Medicare Act and due process required the Secretary of HEW to review the record of the hearing afforded the plaintiff, citing 42 U.S.C. § 1395h(a). We essentially affirm the district court but on different grounds.

II. Federal Question Jurisdiction Under § 1331.

In examining our federal question jurisdiction alleged by appellant under § 1331, we are met with the provisions of 42 U.S.C. § 405(h). This section is part of the Social Security Act, but is incorporated "to the same extent as they are applicable" into the Medicare Act by 42 U.S.C. § 1395ii. Section 405(h) provides:

[1] The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. [2] No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. [3] No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 [§ 1331] of Title 28 to recover on any claim arising under this subchapter.

The Supreme Court in *Weinberger v. Salfi*, 422 U.S. 749 (1975), discussed the jurisdictional bar imposed by this statute to parties who challenged on constitutional grounds those provisions of the Social Security Act which require that the relationship between a wage earner and his wife or step-children must have existed for a fixed time prior to his death as a condition for receiving benefits. The Court reached the merits only with respect to the named individual plaintiffs who had satisfied the requirements of § 405(g) which authorizes judicial review. It dismissed the class action for want of federal question jurisdiction, noting that no allegation was made that class members had exhausted their administrative remedies as required by § 405(g). *Id.* at 764.⁵

In the course of its decision, the Court specifically examined § 405(h). The Court focused on the third sentence of § 405(h) which forbids any action "against the United States, the Secretary, or any officer and employee thereof" brought under § 41 [now § 1331] of Title 28 "to recover on any claim arising under this subchapter." The Court rejected the view expressed by many federal courts that § 405(h) merely required exhaustion of administrative remedies.⁶ The *Salfi* Court said:

That the third sentence of § 405(h) is more than a codified requirement of administrative exhaustion is plain from its own language, which is sweeping and direct and which states that *no* action shall be brought under § 1331, not merely that those actions shall be brought in which administrative remedies have been exhausted. Moreover, if the third sentence is construed to be nothing more than a requirement of administrative exhaustion, it would be su-

⁵ The University urges that § 405(g) was incorporated by § 1395ii. However, § 1395ii lists those specific subsections of § 405 which it intends to incorporate and § 405(g) is conspicuously omitted. Further, such a finding would render superfluous § 1395 ff(b) which authorizes some limited review and which partially incorporates § 405(g). See p. 11 *infra*.

⁶ See, e.g., cases cited at note 7 *infra*.

perfluous. This is because the first two sentences of § 405 (h) * * * assure that administrative exhaustion will be required. [*Id.* at 757 (emphasis in original) (footnote omitted).]

Appellees in *Salfi* argued that they did not seek to “recover on any claim” under the Social Security Act but rather sought to recover under the Constitution. The Supreme Court conceded this argument had some substance, *id.* at 760-62, noting *Johnson v. Robison*, 415 U.S. 361 (1974). However, the Court said that it was “Social Security benefits which appellees seek to recover,” *id.* at 760, and that

[t]o contend that such an action does not arise under the Act whose benefits are sought is to ignore both the language and the substance of the complaint and judgment. [*Id.* at 761.]

Hence, the claims of the class were held to be barred by § 405(h) since, due to failure to exhaust administrative remedies, review under § 405(g) was improper. The Court said that the reach of § 405(h)

extends to any “action” seeking “to recover on any [Social Security] claim”—irrespective of whether resort to judicial process is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions. [422 U.S. at 762.]

The considerations which led Congress to limit review under the Social Security Act apply with equal force to the Medicare program.

The Medicare statute is a complicated one. Judicial review of the amount of all Medicare payments would bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services—based on facts which vary from community to community. These charges are subject to extensive and complicated statutory guidelines and regulations. *See, e.g.*, 42 U.S.C.

§§ 1395ff, 1395p, 1395u; 20 C.F.R. § 405 *et seq.* Determining the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.

Section 405(h) should be read with these complications in mind. We think *Salfi* requires us to follow it literally. The Supreme Court’s approach to § 405(h) in *Salfi* varies substantially from the approach taken by those cases which have found jurisdiction. The citation of *Cappadora v. Celebrezze*, 356 F.2d 1 (2d Cir. 1966), in Justice Brennan’s dissenting opinion demonstrates that the reasoning of those cases was considered by the Court and bolsters our conclusion that they are inconsistent with the *Salfi* decision.⁷ Accordingly, we reject the authority of those pre-*Salfi* cases relied upon by the University.⁸ Since count I sought to obtain payments pursuant to the Medicare Act, § 405(h) precludes the federal courts from assuming jurisdiction under § 1331. Count III seeks similar relief and also would appear to be barred. However, it purports to raise a constitutional equal protection claim. We discuss this aspect of count III in a subsequent portion of this opinion.

III. Jurisdiction Under the APA.

The University asserts that jurisdiction is established independently of § 1331 by the Administrative Procedure Act, 5 U.S.C.

⁷ *See id.* at 787 n.2 (Brennan J., dissenting). Plaintiffs also placed heavy reliance upon *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (3d Cir. 1973), and *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971). These are direct offspring of the *Cappadora* decision. *Rothman v. Hospital Service*, 510 F.2d 956 (9th Cir. 1975), also relies heavily on the *Cappadora* line of cases. The Fifth Circuit appears to have simply assumed jurisdiction. *Mount Sinai Hosp. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, — U.S. — (. . .).

⁸ We are aware that Congress has amended the Medicare Act to create a Provider Reimbursement Review Board whose decisions specifically are made judicially reviewable under the APA. 42 U.S.C. § 1395oo (1970) (Supp. III). This does not alter our view of the prior legislative intent. The amendment is applicable only to accounting periods ending on or after June 30, 1973.

§§ 702-06. While there is some doubt whether the APA in and of itself affords an independent basis for federal court jurisdiction, in this particular case § 702 of the APA would preclude finding jurisdiction in any event. The APA provides that if agency action is "committed" to the discretion of the administrator, it is not subject to judicial review under the APA.⁹ See generally *Greater New York Hospital Association v. Matthews*, — F. Supp. —, 44 U.S.L.W. 2337 (S.D. N.Y., Dec. 11, 1975).

To determine whether Congress intended to commit the issues raised by the University to agency discretion we must carefully examine the Medicare Act. The provision governing the availability of judicial review in this case appeared in the original Medicare Act. It provided for judicial review on behalf of an individual of

[a]ny determination [by the Secretary] * * * as to entitlement under Part A or Part B or as to amount of benefits under Part A * * *. [42 U.S.C. § 1395ff(b) (1970).]

The conspicuous omission of any provision for judicial review of the *amount* of benefits under part B indicates that Congress felt that determination of the proper "reasonable charge" was a matter best left to agency expertise. Cf. *Schillings v. Rogers*, 363 U.S. 666, 674 (1960).

Our view is strengthened by the emphatic language of § 405 (h) which forbids bringing "any claim under § 41 of Title 28." The Supreme Court observed in *Salfi* that at the time § 405(h) was adopted

prior to the 1948 recodification of Title 28, § 41 contained all of that title's grants of jurisdiction to United States district courts, save for several [irrelevant] special purpose * * * grants * * *. [422 U.S. at 756 n.3.]

⁹ 5 U.S.C. § 702. Of course, § 706(2)(A) authorizes a reviewing court to remedy an "abuse of discretion." Thus, all agency discretion is not insulated from judicial review. The crucial question in each case is whether the matter is sufficiently *committed* to agency discretion as to preclude review. See Davis, *Administrative Law Treatise* § 28.16 at 80-81, and 1970 Supplement § 28.16 at 964-65.

Thus, by precluding any resort to § 41, § 405(h) completely eliminated all then existing jurisdictional bases for judicial review. This demonstrates a congressional intent to commit maximum discretion to the Secretary.

The University asserts that whatever the Secretary's discretion within statutory confines, he has so far exceeded the statute as to compel judicial intervention. We therefore turn to the statute and implementing regulations. Section 1395l of Title 42 authorizes reimbursement in full of the "reasonable charges" for compensable part B professional services. The implementing HEW regulations appear at 20 C.F.R. § 405.480 *et seq.* They are amplified in detail in § 3906.2 and § 3906.3 of part A, Intermediary Manual. Section 3906.2 states in part:

Where provider has customarily identified a physician's charges separately from charges for provider services, the physician's charges so established will be considered the customary charges for his professional services, and will afford the basis for determining the reasonable charges for such services.

In contrast, § 3906.3 states in part:

Where, under an existing arrangement between a provider and physician, billings to patients have not separately identified charges of physician's services and charges for provider services a schedule charge will need to be developed based on the physician's professional component.

The Committee read these two regulations together and reached this conclusion:

These two sections, then, reiterate the two alternatives available. In effect, either the provider or physician has established the charge or they have not established a separate charge for the physician's services. If they have, that charge is the basis for Part B reimbursement for physician's services; if they have not, a charge is developed (for Medicare reimbursement purposes) based upon the physician's compensation attributable to patient care services. A sepa-

rate charge has been established when the billings by the hospital have shown a separate charge for the physician's service. This charge must be separated on all billings to patients and third party payors. Only by billing all patients this separate charge can it be established as a charge for that particular service.

The University reads these regulations as interpreted by the Committee as a flat rejection of the mandatory statutory standard of "reasonable charges." HEW, on the other hand, asserts that these regulations do not reject the statutory standard but merely define it. Obviously, there are limits to an agency's definitional leeway.¹⁰ However, we cannot say that it is clearly unreasonable to conclude that a physician's reasonable charge for his services is to be determined by his salary. Therefore, it does not appear that the Secretary has so far exceeded statutory parameters as to remove his actions from the purview of § 405(h).

IV. Jurisdiction to Require Procedural Due Process (Count II).

However, even though we conclude that Congress intended to commit the determination of the proper amount of reimbursement wholly to administrative discretion, we must still face the University's claim under count II that Congress did not and

¹⁰ The limits of the right to define have never been exactly determined. Early sources indicate that the question is not new. Consider, for example, the following dialogue:

"When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean—neither more or less."

"The question is," said Alice, "whether you *can* make words mean so many different things."

"The question is," said Humpty Dumpty, "which is to be master—that's all. * * * They've a temper, some of them—particularly verbs, they're the proudest—adjectives you can do anything with, but not verbs—however, *I* can manage the whole lot of them! Impenetrability! That's what *I* say!"

"Would you tell me, please," said Alice, "what that means?" [L. Carroll, *Through the Looking Glass*, Ch. 6 (emphasis in original).]

could not approve the administrative process employed in this case. The University points out that HEW subjected it to the bureaucratic whim of a nongovernmental Provider Appeals Committee, a majority of the members of which were officers or employees of BCA whose initial decision was being appealed, and who had an institutional interest in the outcome.¹¹ According to HEW's view, the Committee's discretion is essentially unrestrained. Judicial review is barred by § 405(h) and administrative review is precluded by the agreement between HEW and BCA which established the Committee. HEW will not review the Committee's decision even when a provider asserts that the Committee has blatantly ignored governing statutes, regulations, and constitutional requirements.

The Supreme Court has recognized that totally precluding judicial consideration of constitutional issues raises serious constitutional problems. *Weinberger v. Salfi*, *supra*, 422 U.S. at 762; *Johnson v. Robison*, 415 U.S. 361, 366 & n. 8 (1974). Those constitutional problems are greatly intensified when an agency purports to subdelegate its immunity from judicial review to a nongovernmental entity. It is a "cardinal principle" that we are to ascertain whether a construction of the statute involved is "fairly possible" by which such constitutional doubts may be avoided. *Johnson v. Robison*, *supra*, 415 U.S. at 366-67. We are to proceed in what Justice Stewart termed "the candid service of avoiding a serious constitutional doubt." *United States v. Vuitch*, 402 U.S. 62, 97 (1971) (Stewart, J., dissenting in part).

Thus, we must now return to § 405(h) to determine if it precludes our jurisdiction to entertain a due process challenge to the procedures adopted by the Secretary to determine Medi-

¹¹ The intangible effect of institutional loyalty must not be underestimated simply because it is difficult to quantify. See H. Simon, *Administrative Behavior* 13-14 (1957), *quoted in* W. Gellhorn & C. Byse, *Administrative Law: Cases & Comments* 881 (5th Ed. 1970). As Justice Jackson commented, "Men are more often bribed by their loyalties and ambitions than by money." *United States v. Wunderlich*, 342 U.S. 98, 103 (1951). See also *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970).

care reimbursements. Section 405(h) forbids any action under § 1331 "to recover on any claim arising under this sub-chapter." Appellees in *Salfi* argued that this did not bar their constitutional claims since they "arose under" the Constitution and not under the Social Security Act. The Supreme Court recognized that this argument had substance. 422 U.S. at 760. However, it rejected the argument because

not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions. [*Id.* at 760-61.]

The Court also indicated that its decision was influenced by the availability of fully adequate judicial review under § 405(g). The Court said:

In the present case * * * the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus the plain words of § 405(h) do not preclude constitutional challenges. [*Id.* at 762 (emphasis added).]

In the present case, the due process claim has as its primary goal obtaining a constitutionally adequate hearing. Allowing such a hearing will not necessarily affect the University's entitlement to reimbursement or the amount allowed. Secondly, and more importantly, the Medicare Act does not provide the University an adequate alternative means of obtaining judicial review of its due process claim.

We believe that on these two grounds alone, this case is distinguishable from *Salfi*, and thus § 405(h) does not preclude our jurisdiction of count II.¹² However, there is a third basis

¹² The Supreme Court has recently found jurisdiction to review a Social Security beneficiary's claim of a denial of due process. *Mathews v. Eldridge*, — U.S. —, 44 U.S.L.W. 4224 (U.S. Feb. 24, 1976). The Court emphasized that the due process claim was "collateral to his substantive claim of entitlement" and that no other fully effective review was available. *Id.* at . . .

for distinction. Section 405(h) is incorporated into the Medicare Act only "as * * * applicable." § 1395ii. The general rule is that a statute incorporated into another "as applicable" will be read in such a manner "as will give form and effect to the statute into which it is incorporated." *Penrose v. Whiteacre*, 147 P.2d 887, 889 (Nev. 1944), and authority cited therein. If § 405(h) were read to wholly preclude adjudication of the University's due process claim it would raise serious constitutional problems which might impair the force and effect of the Medicare Act. Therefore, we find that Congress did not intend for § 405(h) to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process.

On the merits of count II, the district court made the following finding:

Three of the five Board members who conducted the subject hearing, Chairman Green, Hankle, and Moeller, were BCA employees. BCA had advised the Plan in 1969 on the merits of plaintiff's position and was supportive of the Plan's ultimate decision. Furthermore, BCA was co-contractor with the Plan in providing the intermediary services to plaintiff and the Secretary. The conclusion is inescapable that plaintiff was not afforded a hearing before an impartial decision maker.

The court also found that "both the Medicare Act, 42 U.S.C. § 1395h(a)(1965), and the constraints of due process require that the Secretary review the record of any hearing afforded plaintiff." As a remedy the court remanded the case to the Secretary "for a *de novo* evidentiary hearing before a tribunal that does not contain employees of BCA."

While we appreciate the district court's concern over the BCA personnel serving on the Committee, we find that the makeup of the Committee was constitutionally permissible. See *Winthrow v. Larkin*, 421 U.S. 35 (1975). Moreover, all parties to this appeal seem agreed that the facts are undisputed.

Thus, we cannot see that the Committee's factfinding function prejudiced the University in any way.

However, the parties do dispute the proper interpretation of the HEW regulations and whether these regulations are consistent with the Medicare Act. We agree with the district court that due process precluded vesting the final determination of these issues in the Committee as constituted and we doubt that Congress authorized any such delegation of power.¹³

Thus, we modify the judgment of the district court by eliminating the requirement that the Secretary hold a *de novo* evidentiary hearing. While on remand the Secretary may hold such an evidentiary hearing if it is thought desirable, we direct only that the Secretary adopt and employ appropriate measures to determine the University's contentions concerning the proper interpretation of the Medicare Act and regulations.

V. Jurisdiction to Require Equal Protection (Count III).

Finally, we must consider count III in which the University advances an equal protection claim. The University asserts that the Committee acted arbitrarily and capriciously by disallowing its claim while allowing identical claims of other providers similarly situated who merely happen to have a different bookkeeping system.

¹³ Section 1395(a) authorizes the Secretary to enter into an agreement with [a fiscal intermediary like BCA] providing for the determination by such agency or organization (subject to the provisions of section 1878 [42 U.S.C. § 1395oo] and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required * * *. (Emphasis supplied).

HEW reads the language included in parenthesis to allow the Secretary to enter an agreement which precludes any administrative review whatsoever of a fiscal intermediary's determination. However, this takes the parenthetical too far. The statute may well permit an agreement authorizing a properly constituted intermediary to make final factual determinations. However, the general scheme of the statute requires that the Secretary retain sufficient powers of review to assure that fiscal intermediaries comply with HEW regulations and the Medicare Act.

On its face this appears to raise a constitutional issue.¹⁴ The Due Process Clause of the fifth amendment has been held to embody a guaranty of equal protection by the federal government. See *United States Dept. of Agriculture v. Moreno*, 413 U.S. 528, 533 n.5 (1973). Traditionally, equal protection analysis has required that a governmental classification be "rationally related to a legitimate governmental objective." *Id.* at 533.

Much of our jurisdictional analysis of the procedural due process issue presented in count II would seem to support our jurisdiction of count III, which also arises under the due process guaranty of the fifth amendment. If § 405(h) bars our jurisdiction, the University will have no judicial forum in which to assert its constitutional right to equal protection.

On the other hand, the direct purpose of this claim is to increase the amount of reimbursement to the University. Thus, it appears to fall squarely within the language of § 405(h) and of the Supreme Court in *Salfti*, 422 U.S. at 760-62. Additionally, count III seeks a money judgment against the United States. The doctrine of sovereign immunity probably would permit the Congress to forbid such an action even if based upon a constitutional violation. See *Dugan v. Rank*, 372 U.S. 609, 620 (1963); cf. *Edelman v. Jordan*, 415 U.S. 651 (1974).

We need not reach this difficult issue at this time. Pursuant to count II, we have determined that this case should be remanded to the Secretary for his consideration of the University's position. Consideration of the issues raised in count III must await the Secretary's hearing and decision on the University's claim.¹⁵

¹⁴ The University's complaint in this case is at least somewhat more specific than the conclusory allegations in *Schilling v. Rogers*, 363 U.S. 666 (1960), that the administrative action was "arbitrary and capricious."

¹⁵ As noted in our discussion of count II, the extent of Congress' power to preclude judicial consideration of constitutional issues is itself a difficult constitutional question which has never been clearly

Postponing a decision on count III offers several advantages. In count I, the University has argued that under the proper interpretation of HEW's regulations, it is entitled to full reimbursement. The Secretary may agree. If so, a judicial resolution of the difficult issues presented by count III will be unnecessary. On the other hand, if the Secretary rejects the University's claim, the count III jurisdictional issue will be squarely presented. Should jurisdiction be found, judicial assessment of the merits of the claim will be made substantially easier by the Secretary's authoritative construction of the regulations and articulation of their underlying rationale.

Therefore, we make the following disposition of this appeal:

1) The district court's dismissal of count I for lack of jurisdiction is affirmed for the reasons discussed above;

2) The district court's judgment granting relief on count II is modified by eliminating the requirement of a *de novo* evidentiary hearing before a tribunal that does not include members of BCA, but is affirmed to the extent that it requires the Secretary to make a final administrative determination of the medical fee dispute between appellant and appellees.

3) The district court's dismissal of count III is affirmed on the ground that it is premature but without prejudice to a later action raising the equal protection clause.

A true copy.

Attest:

Clerk, U.S. Court of Appeals, Eighth Circuit

resolved by the Supreme Court. It is the settled federal practice to postpone resolving such constitutional issues until a decision is necessary. *Sullivan v. Meade County School Dist. 101*, — F.2d —, 44 U.S.L.W. 2424 (8th Cir., Feb. 26, 1976).

APPENDIX B

In the United States District Court for the
Eastern District of Missouri
Eastern Division

Faith Hospital Service, a Missouri
Not-for-Profit Corporation,

Plaintiff,

vs.

Blue Cross Hospital Service, Inc. of
St. Louis, Doing Business as Blue
Cross Plan of St. Louis; Blue
Cross Association; General American
Life Insurance Company;
and Casper W. Weinberger, Secretary of Health, Education and
Welfare,

Defendants.

No. 73 C 243 (3).

Memorandum and Order

This matter is before the Court upon defendant, Casper W. Weinberger, Secretary of Health, Education and Welfare's, motion to dismiss.

This action is for review of certain administrative decisions regarding overpayment to the plaintiff as a health services provider under the Medicare Act. Jurisdiction is predicated upon Section 10(a) of the Administrative Procedure Act, 5 U.S.C. §702. Count I alleges that certain decisions of defendant Secretary were arbitrary, wrongful and discriminatory. It is alleged in Count II of the complaint that the appeals procedure provided for by the Secretary for review of administrative decisions does not comport with the due process requirements of the Fifth Amendment. Count III alleges that

the decisions complained of were not within the statute of limitations requirements contained in 42 U.S.C. §§1395 cc, and 1395 gg (erroneously cited by all parties as 42 U.S.C. §§1866 and 1870).

Defendant's motion to dismiss Count I is based upon the assertion that this lawsuit is an unconsented action against the sovereign. The Court finds such a defense to be well taken. It is clear that within the Eighth Circuit that actions such as the one presently at bar are not viable without the permission of the sovereign. *Twin Cities Chippewa Tribal Council v. The Minnesota Chippewa Tribe*, 370 F.2d 529 (8th Cir., 1967). For a thorough discussion of this matter see the February 18, 1975 Order of the Honorable John F. Nangle of this District in *St. Louis University v. Blue Cross Hospital Service, Inc., of St. Louis*, No. 72 C 638 (4). Accordingly, Count I of plaintiff's complaint will be dismissed.

Notwithstanding the unconsented action nature of plaintiff's complaint, Count II of the complaint is permissible since it raises a constitutional question. It is plaintiff's contention that the composition of the Blue Cross Association Provider Appeals Committee is a violation of due process by reason of the required Blue Cross Association affiliation of a majority of the committee members. Such a requirement clearly raises the question of whether or not the procedure provided for by the appeals committee constituted a review by an impartial decision maker. Such a review is clearly required by the holding of *Goldberg v. Kelly*, 397 U.S. 254 (1970). Defendants in their brief supporting their motion for dismissal suggest to the Court that the decision of the appeals committee represents the final non-reviewable determination of the defendant Secretary. The Court finds no evidence within the material submitted to it that indicates that the decision of the appeals committee should be considered a final review by defendant Secretary. It is readily apparent that the Secretary should provide a *de novo* review before an impartial appeals committee in order to satisfy the plaintiff's contentions regarding the Blue Cross As-

sociation Appeals Committee procedures. In order that this action might proceed apace to a final determination a *de novo* review by an impartial appeals committee of the alleged overpayments under the Medicare Act should be had. Such a review will be held before an appeals committee that does not contain employees of the Blue Cross Association and whose procedures comport with due process as enunciated in *Goldberg v. Kelly*, supra.

Count III of plaintiff's complaint is predicated upon the thesis that the actions of the defendants were in violation of statute of limitations provisions contained in 42 U.S.C. §§1395cc and 1395gg. After a careful and close reading of the aforecited statutes the Court finds nothing within them which appears to state a statute of limitations for the actions complained of. Accordingly, the motion to dismiss as to Count III will be granted. In consequence,

It Is Hereby Ordered that defendant's motion to dismiss as to Counts I and III of plaintiff's complaint be and is Granted; and

It Is Further Ordered that defendant's motion to dismiss as to Count II of plaintiff's complaint be and is Denied; and

It Is Further Ordered that the defendants, within a reasonable time, will grant plaintiff a *de novo* evidentiary hearing on its appeal from the subject decision of the plan, with subsequent review thereof by the Secretary in accordance with the discussion of that matter as it appears above.

Dated this 26th day of February, 1975.

/s/ H. KENNETH WANGELIN
United States District Judge

APPENDIX C

BLUE CROSS ASSOCIATION
MEDICARE PROVIDER APPEAL—
COMMITTEE DECISION
DISPUTE BETWEEN
FAITH HOSPITALS
AND
BLUE CROSS HOSPITAL SERVICE,
INC. OF MISSOURI

This provider appeal of a dispute between the hospitals and the Blue Cross Plan was heard by the Blue Cross Association Medicare Provider Appeals Committee on October 4, 1972, Art M. LaValle, BCA, presiding. Other members of the Committee hearing and deciding were George B. Pearson and Sister Mary Vincent O'Donnell, AHA; and Stanley H. Gertzman and Lloyd J. Hermans, BCA. The provider was represented by its counsel, medical director, chairman of the board, and other provider personnel. The Plan was represented by its director of provider reimbursement and manager of hospital consulting. The decision of the Committee was based upon representations and responses to questions during the hearing, including documents furnished the Committee before and during the hearing and post hearing fact finding. In order to evaluate the post hearing submissions more properly, the Committee reconvened in executive session on February 1, 1973.

The dispute concerned (1) Plan recovery of a Part B overpayment. The provider introduced a supplemental statement of appeal at the hearing concerning (2) pension costs and (3) deferred compensation expenses. The last two issues were heard on a written basis.

1. Plan Recovery of a Part B Overpayment

The Plan contended that the specialist-physicians were provider-based physicians, and reimbursement must be made in

compliance with the Regulations and Principles of Reimbursement for services by provider-based physicians. The Plan, in accordance with Regulation Section 405.480ff, Provider Reimbursement Manual Chapter 21, and Blue Cross Association Administrative Bulletin No. 288, requested a refund of the overpayment made by the Part B carrier since the charges paid by the carrier was greater than the compensation received by the physicians.

The hospital collected the amount of the charge from the beneficiary acting as agent for the specialist-physicians. The patient submitted a claim to the Part B carrier for reimbursement. The hospital retained all collections stating they were applied against costs, and the remainder was a "donation" to the hospital from the physicians.

The Plan was of the opinion that:

1. The deposit of \$5,000 did not constitute assumption of the operating costs of the department.
2. The hospital had not established a separate charge for physicians' services prior to July 1, 1966.
3. The hospital had not entered into an arrangement with its physicians prior to July 1, 1966 to permit the direct billing to Medicare beneficiaries by the physicians.

The provider had previously advised the Plan that the specialist-physicians paid for their own expenses of operation in their respective departments; i.e., the hospital had no costs for operating these departments. However, the Plan's audit of the cost reports furnished by the provider established that the provider had continued to operate the departments involved in the appeal, and that the only physician involvement was the deposit of \$5,000 with the hospital to pay for the operation of the departments.

The Plan found that, although separate claims were rendered to the Part B carrier for Medicare patients, the hospital con-

tinued to bill non-Medicare patients for the physician component. After the close of the books, through a series of accounting entries, the cost of furnishing services to Medicare patients was calculated, and the excess developed from payments by the Part B carrier was "donated" to the hospital by the physician. The Plan argued that, in such circumstances, it was incumbent upon the Intermediary to make a determination of the source of the reimbursement (whether initial payment was made by the hospital or the physician) and when any claimed base arrangement became effective. The Plan concluded that the only instance where total Medicare payments (total Part A and Part B) may exceed costs is when the arrangement was in effect before July 1, 1966, and a historic pattern of charges had been established as outlined in Plan Medicare Bulletin No. 125 Section 8.1B(1).

Therefore, since the hospital retained the excess of charges over cost, the Plan made the resulting adjustments to recover the Part B overpayment.

The provider contended the Plan was not entitled to recoup the alleged overpayments by withholding payments of lawful Medicare claims by the hospital, or by demanding additional monthly payments from the hospital until the full amount of the alleged overpayments had been recouped. These payments were made by the Part B carrier directly to the patients in accordance with the reasonable charges billed by the physician-specialists. Furthermore, Title XVIII, Section 1832(a) states that insured persons are entitled to have payments made to them for certain medical services furnished to them, and Section 1833(a) provides for payments for such medical services.

In addition, these arrangements were lawfully entered into by and between the physician-specialists and the hospital in accordance with Title XVIII Section 1801 (noninterference by Federal Government). The action taken by the Plan, therefore, ignored the Law and interfered with the physicians' right to charge a reasonable fee.

The provider argued that the arrangement between the physician-specialists and the hospital was arrived at prior to the advent of Medicare, and the physicians have, from the inception of Medicare, borne all of the expenses of the operation of their departments; it being the position of the hospital that reasonable charges by these physicians should be paid in full by Medicare. This is in accordance with Regulation Section 405.486(3).

The provider stated that, when a physician receives his reasonable charges as billed to his patients, it is the physician's right to dispense with such funds as he wishes, i.e., the physician may donate all or any portion he may desire to the hospital involved.

The provider concluded that the action taken by the Plan is illegal and without authority of the Law. The Plan had attempted to set aside the Part B carrier's determination of the physician's reasonable charges. Therefore, the Plan adjustments should be reversed, and all funds collected by the Plan should be refunded to the hospital.

The Committee finds that the specialist-physicians who performed medical services at the hospital; namely the radiologists, the pathologists, the cardiologists and the anesthesiologists received their compensation from the hospital and are considered hospital-based physicians as defined in the Regulations. Therefore, Regulation Section 405.480ff, Part A Intermediary Manual Section 3906ff, and Provider Reimbursement Manual Section 2108ff have direct application in this situation.

The Committee notes that the hospital had not established a separate charge for the physicians' services prior to July 1, 1966; and that by separating out a physician charge for Medicare billings only, the hospital had not "established" that portion of the combined charge as the provider's charge for the physician's service.

Section 3906.2 of the Part A Intermediary Manual states in part:

"Where a provider has customarily identified a physician's charges separately from charges for provider services, the physician's charges so established will be considered the customary charges for his professional services, and will afford the basis for determining the reasonable charges for such services."

In contrast to this, Section 3906.3 states in part:

"Where, under an existing arrangement between a provider and physician, billings to patients have not separately identified charges for the physician's services and charges for provider services, a schedule charge will need to be developed based on the physician's professional component."

These two sections, then, reiterate the two alternatives available. In effect, either the provider or physician has established the charge, or they have not established a separate charge for the physician's services. If they have, that charge is the basis for Part B reimbursement for physician's services; if they have not, a charge is developed (for Medicare reimbursement purposes) based upon the physician's compensation attributable to patient care services. A separate charge has been established when the billings by the hospital have shown a separate charge for the physician's service. The charge must be separate on *all* billings to patients and third party payors. Only by billing all patients this separate charge can it be established as a charge for that particular service.

The Committee observes that by separating out a physician charge for Medicare billings only, the hospital has not "established" that portion of the combined charge as its charge for that physician's service. If only Medicare is billed a separate charge, then Section 3906.3 must be applied, and the charge established for billing must be related to the professional component of the physician's compensation. A charge developed merely for internal accounting or financial purposes would not be adequate to establish the reasonable charge as that charge has not been identified to the patient.

After careful consideration of the applicable Regulations and Manual Sections, the Committee concludes that the provider has not met the intent of the Medicare program by its failure to establish a separate charge in billings to all patients and third party payors. Therefore, the Committee unanimously upholds the Plan's decision.

The provider, in a post-hearing "motion", averred that the recently enacted H.R. 1 eliminated any liability of this provider for the repayment of the alleged overpayments. The Committee finds that the three year statute of limitations on recoupment of overpayments as set out in Section 281 applies only to post 1968 situations, and therefore, the Plan was within the three year period for recoupment for all post 1968 cases. It is implicit in the cited section that it does not apply to notices of payments made prior to January 1, 1969. Therefore, the Committee rejects the post hearing "motion."

2. Elimination of Pension Costs

The Plan allowed pension costs of \$11,379, \$8,063, and \$8,063 for the years 1967 through 1969, respectively. The Plan contended that these costs must be disallowed because the pension plan did not meet certain criteria as promulgated in Section 2142 of HIM-15:

1. Eligible employees were not identified.
2. The pension plan had evidently not been communicated to all employees as shown by the fact that participants included certain highly paid employees only.
3. The pension plan discriminated in favor of certain employees.
4. Payments were not made within 75 days of the close of the accounting period.
5. The pension plan did not specify the time and manner in which benefits were to become vested.

6. The pension plan did not meet vesting requirements specified regarding Medicare termination, dissolution of plan, etc.

In addition, the Plan disagreed with the provider's assertion that, if the pension costs are disallowed, they should be included as salary, since the required reporting for income and payroll taxes had not been effected.

The provider contended that, if these costs were disallowed as pension expenses, they should be included as salary expense since these policies were tax sheltered annuities, and any employee could elect to take an increase in salary by this method in lieu of cash compensation.

The provider further argued that the Plan's interpretation and resulting adjustments were not applicable, since Section 2142ff of HIM-15 was not incorporated as a manual revision until 1970 which was subsequent to the years in question.

Upon examination of the documentation submitted by the provider, the Committee finds that the payments for the pension plan do not qualify as an allowable cost under the Medicare program because of the deficiencies noted by the Plan.

Although the pertinent manual sections were not published until a subsequent year, pension costs have always been subject to review for their reasonable and appropriate application under the Medicare program. The guidelines, as published, were merely a clarification of the policy previously followed in the evaluation of these costs.

In conclusion, the Committee upholds unanimously the Plan's Adjustments in precluding these costs as not being related to patient care.

3. Elimination of Deferred Compensation

The Plan disallowed payments (\$17,500 for 1968 and \$17,500 for 1969) claimed for a deferred compensation policy for the provider's medical director for the following reasons:

1. The plan was not evidenced by a written agreement.
2. The method of calculating the contributions in the fund was not prescribed.
3. The plan's assets were owned and controlled by the hospital, because it was both owner and beneficiary of the policy.
4. Vesting rights had not been established.
5. The total compensation paid to the medical director was not reasonable.

The provider claimed that it purchased a retirement annuity contract on the life of its medical director in August 1970 to satisfy the requirement that all deferred compensation be funded within 75 days after the close of each fiscal year, and any amounts accrued as of July 1, 1970 be funded within 75 days. After reviewing the Plan's contention concerning pension costs, the provider then asserted that the premiums previously shown as pension costs should also be considered deferred compensation.

Based on the documentation submitted, the Committee finds that these costs do not meet the criteria established for deferred compensation, since the guidelines found in Section 2140ff of HIM-15 reiterate the policy previously followed in evaluating these expenses.

The Committee's decision to uphold the Plan's adjustments was unanimous.

APPENDIX D

United States Court of Claims

Whitecliff, Inc., d/b/a Whitecliff Manor,	}	Cause No. 407-74
Plaintiff,		
v.		
United States,		
Defendant.		

Decided: May 12, 1976

Davis, Judge, delivered the opinion of the court:

This controversy between a provider of services under the Medicare program and the Government presents primarily a dispute over 42 U. S. C. § 1395x(v)(1) (1970),¹ relating to the reimbursement to be made to a Medicare provider. Both parties have moved for summary judgment but we find that we cannot dispose of the case finally.

By contract accepted by the Government in 1966, plaintiff Whitecliff, Inc., operating an extended care facility, became a Medicare provider and thus entitled to reimbursement by the Government for reasonable costs incurred in giving services to Medicare beneficiaries. Whitecliff designated the Blue Cross Association (BCA) and Blue Cross of Northern Ohio (BCNO) as its fiscal intermediaries.²

¹ Statute citations are to the 1970 *Code* unless otherwise noted, because later amendments are inapplicable to this case. All section citations, standing alone, are to title 42 of the *Code*.

² A fiscal intermediary is a public agency or private organization which contracts with the Secretary of Health, Education, and Welfare, under 42 U. S. C. § 1395h(a), to determine the amount of reimbursement to be paid to providers and to make the payments. The contract may require the intermediary to perform additional services. See 42 U. S. C. §§ 1395h(a), (c).

In 1970 Whitecliff instituted a work measurement program which purportedly revealed that its actual Medicare costs for 1967-1970 exceeded the reimbursement received from the Government. Whitecliff submitted a request for a retroactive adjustment under 42 U. S. C. § 1395x(v)(1) to correct the alleged inadequate reimbursement. BCNO and BCA each denied the request, and Whitecliff appealed to the BCA Medicare Provider Appeals Committee, in accordance with a disputes procedure established by the BCA in 1968. After a hearing, the Appeals Committee upheld BCA's denial of the claim. Whitecliff then filed suit in this court for \$213,755, the amount of the alleged underpayment, asserting that it is entitled to a retroactive adjustment and that it was denied due process because the BCA Medicare Provider Appeals Committee was not an impartial decision-maker. The Government defends on the grounds, first, that the social security statute precludes any judicial review of the intermediaries' reimbursement determinations, and, second, that plaintiff's arguments have no merit.

[Judicial Review of Intermediaries' Reimbursement Determinations]

A number of courts have considered the permissibility and scope of judicial review of Medicare provider reimbursement disputes. No consensus has emerged on whether courts may review the merits of reasonable cost determinations (*see, e.g., Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co.*, 311 F. Supp. 405, 408-09 (E. D. Wis. 1970) (court may not review amount determined to be reasonable cost); *Temple Univ. v. Associated Hosp. Serv.*, 361 F.Supp. 263, 267-70 (E. D. Pa. 1973) (court had jurisdiction to review merits of determination that a certain transfer of funds was restricted and therefore deductible from Medicare reimbursement); *Coral Gables Convalescent Home, Inc. v. Richardson*, 340 F.Supp. 646, 650 (S. D. Fla. 1972) (court could not make *de novo* reasonable cost determination, but court suggested that it might review for sub-

stantial evidence after an administrative hearing was held)), but the courts have uniformly sustained judicial review at least for compliance with the Constitution and the governing statute. See, e.g., *Aquavella v. Richardson*, 437 F.2d 397, 400-02 (2d Cir. 1971); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 666-68 (2d Cir. 1973); *Rothman v. Hospital Serv.*, 510 F.2d 956, 958-60 (9th Cir. 1975); *Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co.*, *supra* at 409; *Americana Nursing Centers, Inc. v. Weinberger*, 387 F. Supp. 1116, 1118-19 (S. D. Ill. 1975); *South Boston Gen. Hosp. v. Weinberger*, 397 F. Supp. 360 (W. D. Va. 1975). We accepted this scope of review in our order in *Goldstein v. United States*, 201 Ct. Cl. 888, *cert. denied*, 414 U. S. 974 (1973).

The Government contends, however, that the Supreme Court's recent decision in a social security benefits case, *Weinberger v. Salfi*, 422 U. S. 749 (1975), implicitly overruled these prior decisions and endorsed the Government's position that there is no review at all of Medicare provider determinations such as the one now before us. In *Salfi* the Supreme Court ruled that 42 U. S. C. § 405(h)³ precludes district court review of social security benefit decisions, except insofar as review is authorized elsewhere in the Social Security Act. *Id.* at 756-63. Because Section 1395ii of 42 *United States Code* makes Section 405(h) applicable to the Medicare program, the Government argues that Section 405(h), as interpreted in *Salfi*, prohibits judicial review of all Medicare determinations other than those few for which the act expressly provides review. For the years in question, the act explicitly treats judicial scrutiny of specified Medi-

³ Section 405(h) states:

"The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 [now the sections of Title 28 delimiting district court jurisdiction] to recover on any claim arising under this subchapter."

care determinations only in 42 U. S. C. § 1395ff, which does not authorize review of the type of decision appealed by plaintiff.⁴

We decline the invitation to extend *Salfi's* reading of Section 405(h) to this Medicare case. The social security provisions with which the Supreme Court dealt in *Salfi* authorize appeals of all decisions made after hearings, without limitation as to issues;⁵ the practical effect of the *Salfi* decision was simply the enforcement of the Section 405(g) procedures and prerequisites to judicial review. See also *Mathews v. Eldridge*, U. S. Sup. Ct. No. 74-204, decided Feb. 24, 1976 (slip op. at 4-10). By contrast, the Medicare statute's express review provisions in effect prior to 1973 apply to extremely limited categories of cases involving providers.⁶ To import into the Medicare program the *Salfi* preclusion of judicial review (except as expressly authorized) would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to

⁴ 42 U.S.C. § 1395ff(c) entitles an institution to a hearing by the Secretary and to judicial review under Section 405(g) only after a decision to terminate the institution as a provider of services or a determination that the institution is not a provider of services. Other parts of 1395ff cover the rights of individual Medicare beneficiaries to hearings and appeals.

In 1972 and 1974, Congress enacted provisions and amendments greatly expanding statutory review of Medicare provider reimbursement determinations. An amendment of 1972 established a Provider Reimbursement Review Board with jurisdiction to review reimbursement disputes where the amount in controversy exceeds \$10,000. Social Security Amendments of 1972, § 243, 86 Stat. 1420, 42 U. S. C. § 1395oo. In 1974 Congress enlarged the review provision of 1395oo to grant providers the right to obtain judicial review, in a district court, of any decision of the statutory Board and of any reversal, affirmance, or modification of the Board's decision by the Secretary, Pub. L. No. 93-484, § 3(a), 88 Stat. 1459 (1974), 42 U. S. C. § 1395oo(f)(1). These provisions apply only to cost reporting periods ending on or after June 30, 1973. * * *

⁵ Section 405(g) entitles any individual who was a party to a hearing to appeal any final decision made after a hearing. Because Section 405(b) entitles any individual prejudiced by an initial decision on an application for benefits to a hearing, the review secured by Section 405(g) potentially covers every benefits decision.

⁶ See note 4, *supra*.

accord absolute finality to adjudications by private organizations like the BCA. Such a result would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review.⁷ We cannot assume that the Supreme Court would extend the *Salfi* interpretation of Section 405(h) to Medicare cases, where the consequences would be so dramatically different, and therefore we adhere to the pre-*Salfi* view of judicial review of Medicare provider disputes; where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions.⁸ In this court, 28 U. S. C. § 1491 (the Tucker Act) is the pertinent jurisdictional provision both because of plaintiff's contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers. Cf. *United States v. Testan*, U. S. Sup. Ct. No. 74-753, decided March 2, 1976.

[Retroactive Corrective Adjustment]

The standard of review set forth in *Goldstein, supra*, encompasses plaintiff's claim for money judgment, based as it is on an

⁷ See generally *Johnson v. Robison*, 415 U. S. 361, 366-68, 373-74 (1974); *Barlow v. Collins*, 397 U. S. 159, 166-67 (1970); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F. 2d 663, 667-68 (2d Cir. 1973); Homer & Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L. J. 107, 26-29 (1974). In *Salfi* the Supreme Court distinguishes *Johnson v. Robison, supra*, a case in which the Court held that a statute similar to 42 U. S. C. § 405(h) did not preclude review of the question raised, in part on the ground that review of a constitutional challenge to the statute would have been cut off if the interpretation contended for by the Government in *Johnson* had prevailed, while no constitutional challenges would be denied review under the Social Security Act. See 422 U. S. at 762.

⁸ For disputes over reimbursements with respect to fiscal periods ending on or after June 30, 1973, Congress has already resolved the problem of judicial review; only disputes where the amounts in controversy are less than \$10,000 are left untreated by statute. See note 4, *supra*.

allegation that the BCA Medicare Provider Appeals Committee's decision violated the Medicare statute. Relying on 42 U. S. C. § 1395x(v)(1)(B) (1970), which states that the regulations "shall * * * provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," plaintiff challenges the Committee's rejection of its attempt to use its work measurement study to prove that its Medicare reimbursements for 1967-1970 were inadequate. The Government's position is that it is immaterial that Whitecliff's work measurement study may show that its Medicare reimbursements for 1967-1970 were inadequate. The first leg of the argument is that, under Section 1395x(v)(1), the Secretary of Health, Education and Welfare is authorized to promulgate regulations setting forth the allowable methods for determining costs. The second leg is that the Secretary approved only two pertinent methods—the "departmental" and the "combination," 20 C. F. R. §§ 405.452 (a) (b)—but did authorize use of a "more sophisticated method" if the provider obtained prospective approval 20 C. F. R. § 405.453(d)(2)(ii). The third leg is that plaintiff admittedly used the "combination" method and did not seek or obtain advance approval for any other method.¹⁰ It follows, according to the Government, that plaintiff is precluded from any further reimbursement even though it can show that, for its circumstances, the "combination" method led to inadequate reimbursement; the failure to ask for and obtain advance approval of some better method of determining costs is enough to bar the provider.

⁹ These are methods for allocating or apportioning costs between Medicare patients and the provider's non-Medicare patients. Plaintiff's complaint is that the "combination" method it followed led in its case to inadequate allocation of costs to its Medicare patients. It is this difference for which Whitecliff is suing.

¹⁰ See note 9 *supra*. Plaintiff's work measurement study did not utilize the "combination" or "departmental" methods.

The answer, we think, is that the statute's retroactivity provision—quoted above—does not permit the Secretary to disregard the significant fact that his two approved methods of cost-determination can lead to inadequate reimbursement in certain circumstances and in particular cases. That was the ruling in *Kingsbrook Jewish Medical Center v. Richardson*, 486 F. 2d 663 (2d Cir. 1973), in which the provider maintained, and the Government conceded, that the particular method there involved could result in inaccurate reimbursement in certain situations (including that plaintiff's). The Second Circuit held that the corrective adjustment mandated by 1395x(v)(1) applies wherever a cost method produces an inaccurate reimbursement and was "designed to rectify mistakes made by HEW in formulating a particular method of determining cost." 486 F. 2d at 669, 670. Obviously a regulation permitting a provider to seek a modified cost-method *for the future* is no substitute for the statutory requirement of "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."¹¹ The Secretary cannot excuse his agency or his agents (here, the BCA) from the statutory duty to make such retroactive adjustments by failing to promulgate the prescribed regulation or by using in its place regulations permitting only a prospective change of method and a retroactive adjustment to

¹¹ The Government contends that Section 1395x(v)(1) calls only for an annual adjustment, at year-end, when the total of the interim (monthly or more frequent) payments made under Section 1395g exceeds or falls below the reimbursement calculated on the basis of the cost report filed at year-end. The wording of the statute leaves no room for such interpretation. It requires adjustment when the "reimbursement produced by the methods of determining costs" proves either inadequate or excessive. Under the regulations, the only reimbursement produced by the cost-determining methods is the reimbursement determined at the end of a fiscal period, after a provider has submitted its cost reports to which these methods are applied. The interim payments are merely monthly (or more frequent) estimates of costs, to which Section 1395x(v)(1) makes no reference. See 20 C. F. R. §§ 405.451-454; *Kingsbrook Jewish Center v. Richardson*, *supra*, 486 F. 2d at 669.

bring interim payments into agreement with the annual reimbursement produced by a method of determining costs. See *Kingsbrook Jewish Medical Center v. Richardson*, *supra*, 486 F. 2d at 669-70.

The BCA Medicare Provider Appeals Committee therefore violated the Medicare statute when it insisted upon treating plaintiff's work measurement study as an unrecognized method of cost apportionment and found no support in the law or regulations for the requested retroactive adjustment, regardless of the accuracy of the work measurement study. The Committee should instead have determined whether Whitecliff had proved that its actual 1967-1970 Medicare costs (limited by reasonableness) exceeded the reimbursements it received under the "combination" method of determining costs and have granted a retroactive adjustment if Whitecliff had proved its claim that the method was inadequate for Whitecliff's situation. Because the Committee made no findings on Whitecliff's actual costs for 1967-1970, no comparison of those costs with its reimbursements for those years, and no evaluation of the accuracy of the method under which the provider was paid, we must remand to the Secretary for a hearing at which Whitecliff will be given an opportunity to prove its actual costs and the inadequacy of its reimbursement.¹²

We need not and do not decide plaintiff's remaining contention that the composition of the BCA Appeals Committee violated due process in that three of the five members were BCA employees. However, we note that one district court has found this issue to be substantial and another has ruled that the BCA Committee's composition does deprive a provider of the impartial decision-maker required by cases such as *Goldberg v. Kelly*, 397 U. S. 254, 271 (1970). See *Temple Univ. v. Associated Hosp. Serv.*, 361 F. Supp. 263, 267 (E. D. Pa. 1973); *St. Louis*

¹² 42 U. S. C. § 405(h) seems to us to indicate that federal courts do not have jurisdiction to try and determine in the first instance a provider's reasonable costs. See note 3 *supra*.

Univ. v. Blue Cross Hosp. Serv., Inc., 393 F. Supp. 367, 371 (E. D. Mo. 1975); *Faith Hosp. Serv. v. Blue Cross Hosp. Serv., Inc.*, 393 F. Supp. 601, 602 (E. D. Mo. 1975).¹³ See also *Homer & Platten, supra* note 7, at 131-33. But see *Community Hosp. of Indianapolis, Inc. v. Blue Cross Ass'n*, No. IP 73-C-615 (S. D. Ind. Dec. 18, 1974) (composition of Committee does not violate due process). The Secretary could obviate any due process challenge to the decision on remand by providing plaintiff with a hearing before a body not composed in its majority of BCA employees.

In conclusion, we hold that the plaintiff is entitled to a retroactive adjustment¹⁴ in its reimbursement if it can prove that its actual reasonable costs for 1967-1970 exceeded its reimbursement on the "combination" method, but otherwise deny plaintiff's motion for summary judgment, deny the Government's cross-motion and remand the case to the Secretary of Health, Education, and Welfare pursuant to Rule 149 and our remand statute, Pub. L. No. 92-415, 86 Stat. 652 (1972), 28 U. S. C. § 1491 (Supp. IV, 1974), for a hearing on plaintiff's reasonable costs and the adequacy of its reimbursements for the years 1967-1970, and for a retroactive corrective adjustment¹⁵ if plaintiff

¹³ In decisions issued after this opinion was prepared and adopted, the Eighth Circuit modified the Eastern District of Missouri's decisions in *St. Louis University* and *Faith Hospital*. The Circuit Court found, contrary to the district court, that the composition of the Committee is constitutionally permissible but agreed that due process precludes vesting the final determination of the issues in the Committee as constituted. Therefore, the court merely modified the district court's judgment, retaining the requirement that the Secretary make the final determinations. *St. Louis Univ. v. Blue Cross Hosp. Serv.*, Nos. 75-1274 & 75-1293 (8th Cir. Apr. 12, 1976); *Faith Hosp. Ass'n v. Blue Cross Hosp. Serv.*, Nos. 75-1301 & 75-1344 (8th Cir. Apr. 12, 1976).

¹⁴ Subject to any valid regulation, applicable to this case, which may limit the amount of retroactivity of corrective adjustments under § 1395x(v)(1). See *Kingsbrook Jewish Medical Center v. Richardson*, *supra*, 486 F. 2d at 679.

¹⁵ See note 14, *supra*.

proves that its reimbursements were inadequate. Further proceedings in this court are stayed for a period of six (6) months from the date of this decision. Plaintiff's counsel is designated to advise the court by letter at intervals of 90 days, of the status of remand proceedings. The parties and the Secretary should also take note of Rule 150.
